MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b

04229

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince Georges

City or town Glenn Dale (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 69 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1313- You St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war –

3. (a) FULL NAME EMMA R. ACTON

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Henry Acton, deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 4, 1879

8. AGE: Years	Months	Days	If less than one day
68	4	18	..... hrs. ..... min.

9. Birthplace Waldorf, Charles Co., Maryland
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name ? Williams
13. Birthplace ? Maryland

MOTHER
14. Maiden name unknown
15. Birthplace ? Maryland

16. Informant deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26 1947 (month) (day) (year)

Cemetery or crematory Waldorf M. E. Cemetery

Location Waldorf, Maryland

18. Funeral director Thomas F. Murray Funeral Home

Address 9007 Nichols Ave S.E. Dc.

19. May 23, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 23 1947, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 25 1947, to MAY 23 1947 and that I last saw h.e.r alive on MAY 23 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 mo.
Diabetes Mellitus	2 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other

Address Glen Dale Md. Date signed 5/23/47

M

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

04230

131a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Prince Geo. Co.
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2-B. East Way
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Julia A. Baldwin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Herbert B. Baldwin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 24 1867

8. AGE: Years	Months	Days	If less than one day
79	11		hrs. min.

9. Birthplace: Iowa (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Peter Scheib
13. Birthplace: Iowa

MOTHER
14. Maiden name: unknown
15. Birthplace: Iowa

16. Informant: Gail M. Harper
Address: 2-B. East Way, Greenbelt Md

17. Burial, cremation, or removal (Which?) Burial Date thereof: 5-23-47 (month) (day) (year)
Cemetery or crematory: Panora Iowa
Location:

18. Funeral director: W W Chamberlain Co
Address: River dale. Md.

19. (Date rec'd by registrar) May 23 1947 James Levey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22, 1947, at 11.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10, 1945, to May 1947
and that I last saw her alive on April 25, 1947

Immediate cause of death	DURATION
Coronary thrombosis	½ hr.
Due to: hypertensive cardio-renal disease	6 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hans Wodele M.D.
M. D. or other
Address: 30-B Ridge Rd Greenbelt Md Date signed: 5-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 179X

CERTIFICATE OF DEATH

Reg. Dist. No. 04231 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7½ days
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 7½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5604 37th Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Earl Bauman

3.(b) Social Security Number: 577-07-7823

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Thelma
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 7, 1907

8. AGE: Years	Months	Days	If less than one day
40	3	20	..... hrs. ..... min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Wash. Gas Light Co.

FATHER
12. Name: Albert Bauman
13. Birthplace: Virginia D.C.

MOTHER
14. Maiden name: Ida Simmons
15. Birthplace: Virginia D.C.

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31, 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor, Md.

16. Funeral director: J. J. Collins
Address: 3814 14th N.W. Wash. D.C.

19. 5/28/1947 (Date rec'd by registrar) Amanda Downes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1947 19..... at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Toxemia	
Due to: Acute toxic hepatitis	
Due to: Acute toxic nephritis	
Due to: Carbon tetrachloride poisoning	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: May 15, 1947
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: James J. Bond Deputy Medical Examiner M.D. or other
Address: Hyattsville Md. Date signed: 5-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of age and birthdate is shown on G 111 8/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

147d

04232

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's General Hospital

City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eight days and 20 min.

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? Eight days and 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Lynchburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 726 Church St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Raleigh
BEAM, Walter

3.(b) Social Security Number 718-10-6136

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Rose

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18, ~~1880~~ 1889

8. AGE: Years	Months	Days	If less than one day
57 ~~56~~	11	10	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: R.R. Ticket agent

11. Industry or business

FATHER
12. Name: Edward Beam
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Kate Bennett
15. Birthplace: North Carolina

16. Informant: Mrs. Rose Beam (wife)
Address: 8500-48th Ave., Berwyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31, 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Washington D.C.

18. Funeral director: E. Giggie Sons

Address: Hyattsville Md.

19. 5/30 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28. 47 at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac failure.	
Due to	
Due to	
Other conditions: Ca of Liver - primary lesion in left upper lobe of lung	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca of Liver Date of op. 5-27-47

Autopsy results: Ca of liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Floyd W Hughes M.D.
M. D. or other

Address: George Gerard Hosp. Date signed: 5-29-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

04233

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Pr. Geos. Co.
City or town: Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 Yrs
Hospital, Institution, or street address where death occurred:
5117 You St S.E.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geos Co
City or town: Bradbury Hgts Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5117 You St SE Wash 19 D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Virginia Lee Birckhead

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widdowed

6.(b) Name of husband or wife: Everette Birckhead
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1864

8. AGE:

Years	Months	Days	If less than one day
83		21	..... hrs. ..... min.

9. Birthplace: BALTIMORE - MD (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: Thos. Owings
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ellen Carpenter
15. Birthplace: Maryland
16. Informant: Gilbert Birckhead
Address: 5117 You St SE. Wash 19, D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 47 (Month) (Day) (Year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.
18. Funeral director: W.W. Chambers Co
Address: 517-11 St SE
19. May 28 19 47 (Date rec'd by registrar) Carrie F. Campbell (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 19 47, at 8:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 47, to May 27 19 47
and that I last saw her alive on May 23 19 47

	DURATION
Immediate cause of death: Congestive Heart Failure	5 Hours
Due to: arteriosclerotic heart disease	2 Years History
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: W. Suit Pilchue M.D. (M. D. or other)
Address: 6906 Pilchue Road SE Wash 19 D.C. Date signed: 5/27/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163A

04234

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ hrs

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? 4½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. Canary Trailer Camp

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: CLAUDE RANDOLPH BISHOP

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude F. Bishop

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): October 31, 1914

8. AGE: Years	Months	Days	If less than one day
32	6	16	....hrs. ....min.

9. Birthplace: Charlottesville, Va.
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business: Guthrie Lithograph, D. C.

FATHER — 12. Name: William Nimrod Bishop

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: Betsy Leona Pritchett

MOTHER — 15. Birthplace: Va.

16. Informant: Reaber Gertrude Buchanan

Address: 813 Madison Ave. wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19, 1947. (month) (day) (year)

Cemetery or crematory: Arlington Cemetery

Location: Arlington Va

18. Funeral director: E. Gasche sons

Address: Hyattsville Md

19. May 19 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1947 at 8:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Toxemia	
Due to Acute phosphorus	
Poisoning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 5-14-47

Where did injury occur? Beltsville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

How? Took rat poison Injured at work?

Deputy Medical Examiner

23. SIGNATURE: [illegible] M. D. or other

Address: Forestville Md Date signed: 5-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170d

CERTIFICATE OF DEATH

Reg. Dist. No. 04235 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Croome,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Floyd A. Bolin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-18-26

8. AGE: Years	Months	Days	If less than one day
21			hrs. min.

9. Birthplace Narrows, Virginia (Town, county, and state)
10. Usual occupation student
11. Industry or business

FATHER
12. Name Lewis Bolin
13. Birthplace West Virginia

MOTHER
14. Maiden name Mary
15. Birthplace West Virginia

16. Informant Ray Bolin
Address Croome, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 19, 1947 (month) (day) (year)
Cemetery or crematory Remington
Location Fauquier Co. Va.
18. Funeral director A. W. Pettyjohn
Address Fauquier 202 S. Main St
19. 5/19 (Date rec'd by registrar) 19 47 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-19 19 47, at 12:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Fracture of the skull	
Due to Fracture of the right femur and tibia and fibula	
Other conditions Crushed pelvis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-18-47
Where did injury occur? Seat Pleasant Pr. Geo. Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Central Ave.
Means of injury Driver of motorcycle in collision Injured at work? no.

23. SIGNATURE Deputy Medical Examiner M. D. or other
Address Fauquier Date signed 5-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

04236

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Hyattsville,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5801 Queens Chapel Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SUSIE BOWLING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 11, 1865

8. AGE: Years 82 | Months 3 | Days 17 | If less than one day: hrs. min.

9. Birthplace: Bryantown, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Benjamin F. Bowling
13. Birthplace: Charles Co., Md.

MOTHER
14. Maiden name: Mary E. Morton
15. Birthplace: Prince Geo., Co, Md.

16. Informant: J.B. Bowling
Address: 3133 Conn. Ave., N.W. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1947 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Bryantown, Maryland

18. Funeral director: James F. Ryan
Address: 317 Penna. Ave., S.E. D.C.

19. May 28 1947 (Date rec'd by registrar) Mrs. Jas Lovere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 19 47 at 200a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47, to May 28 19 47 and that I last saw her alive on May 27 19 47

Immediate cause of death: Congestive heart failure — DURATION: 10 days
Due to: Arteriosclerotic Heart disease
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas F. Collins M.D. (M. D. or other)
Address: 332 Hyatt NE Date signed: 5-31-47

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 04237

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Deanwood Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs. in County
Hospital, Institution, or street address where death occurred:
5106 Nye Street
How long in hospital or institution? One and one half weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6421 K St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jennie Virginia Bradley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: Robert Bradley (deceased)
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): (Unknown) 1861

8. AGE: Years: 86? Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Nottingham, Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business:

FATHER
12. Name: Washington West
13. Birthplace: Nottingham, Md.

MOTHER
14. Maiden name: Mary —?
15. Birthplace: Nottingham, Md.

16. Informant: Mrs. Edith Williams (granddaughter)
Address: 5106 Nye St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 31 1947 (month) (day) (year)
Cemetery or crematory:
Location:

18. Funeral director: Henry L. Washington & Son
Address: 467 N St N.E. Wash. D.C.

19. May 31 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31, 1947, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1946, to May 31 1947 and that I last saw her alive on May 29 1947

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: Hypertensive Cardio-Vascular Disease	unknown
Due to:	
Other coadditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: John W. Robinson, M.D. M. D. or other
Address: 1001 Eastern Ave. NE Date signed: 5/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

C4238

CERTIFICATE OF DEATH

Reg. Dist. No. 242

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince George
City or town Fort Foote
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEDENT:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Fort Foote
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7100 Ogon Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Milton B. Brooke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Florence A. Brooke
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 1st 1871

8. AGE: Years 76. Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Prince George Co Md.
(Town, county and state)

10. Usual occupation
11. Industry or business Merchant.

FATHER
12. Name Augustus B Brooke
13. Birthplace Charles Co Md.

MOTHER
14. Maiden name Margaret Ann Franch
15. Birthplace Prince George Co Md

16. Informant Mrs Florence A. Brooke
Address 7100 Ogon Hill Rd. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31st 1947 (month) (day) (year)
Cemetery or crematory Rock Creek Cemetery.
Location Washington DC

18. Funeral director J Wm Lee Sons Co
Address 800 - 4th St NE

19. May 29 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1945 to May 29 1947 and that I last saw him alive on May 25 1947

Immediate cause of death	DURATION
Coronary sclerosis	
Due to Gen. arteriosclerosis	
Due to	
Other conditions Obliteration endarteritis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. Schwartzman (M. D. or other)
Address 2015 - Nichols Ave. S.E. Date signed 5.29.47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04239

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: P. Geo.
City or town: near Mitchellville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P. Geo.
City or town: Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: Henry Brown

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of ~~husband~~ or wife: Nancy Brown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): unknown (1873)

8. AGE: Years: 74 | Months: — | Days: — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Charles Co. Md (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: Same

FATHER
12. Name: Geo. W. Brown
13. Birthplace: Chas. Co. Md

MOTHER
14. Maiden name: Caroline Shy
15. Birthplace: Chas. Co. Md

16. Informant: Nancy Brown
Address: Mitchellville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26 47 (month) (day) (year)
Cemetery or crematory: Holy Family Woodmoor
Location: Mitchellville P.O. Pr. Geo Co. Md
18. Funeral director: Martin F. Ladson Jones
Address: Bowie Md

19. May 25 19 47 (Date rec'd by registrar) Louise H. Peach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 47 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 19 47 to May 22 19 47 and that I last saw h.v.n. alive on May 22 19 47

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Arteriosclerosis	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: G. E. Lancaster M.D. (M. D. or other)
Address: Bowie, Md Date signed: May 24 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04240

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 10 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 649 N. St. e. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LUE ELLEN BROWN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20, 1924

8. AGE: Years	Months	Days	If less than one day
22	9	11	hrs. min.

9. Birthplace: Sumpter, South Carolina
(Town, county, and state)

10. Usual occupation: Dish Washer

11. Industry or business: - - -

FATHER — 12. Name: Jimmy Brown
13. Birthplace: Sumpter, South Carolina

MOTHER — 14. Maiden name: Daisy Smith
15. Birthplace: Sumpter, South Carolina

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 2, 1947 (month) (day) (year)
Cemetery or crematory:
Location: to Washington, D.C.

18. Funeral director: Wm T Tolbert
Address: 1308-6 st n w

19. May 1, 1947 Rowland S Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 1 1947, at 11 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 29 1947, to MAY 1 1947
and that I last saw her alive on MAY 1 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale Md. Date signed: 5-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b

04241 243

Reg. Dist. No. 2

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 1 day
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 524 Alexander Place, N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME MAGGIE BROWN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Separated

6.(b) Name of husband or wife: Robert Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 28, 1913

8. AGE: Years	Months	Days	If less than one day
33	4	11	hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Veterans Administration

FATHER
12. Name: George Dunham
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Land
15. Birthplace: South Carolina

16. Informant: Deceased
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof: May 11, 1947 (month) (day) (year)
Cemetery or crematory:
Location: Washington, D C.
18. Funeral director: John T. Rhines & Co.
Address: 3rd & Eye St., S. W., Washington DC

19. May 11 1947 Rowland S. Phillips (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 9 1947, at 7 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 7 1947, to MAY 9 1947 and that I last saw her alive on MAY 9 1947

	DURATION
Immediate cause of death: PULMONARY TUBERCULOSIS	8 mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 5-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04242

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Sacred Heart Home

How long in hospital or institution? 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4710 Edgemoor Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cordelia Cissel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 28, 1866

8. AGE: Years	Months	Days	If less than one day
80	6	28	..... hrs. ..... min.

9. Birthplace Montgomery Co. Maryland (Town, county and state)

10. Usual occupation Housewife.

11. Industry or business Own home.

FATHER 12. Name Richard Cissel

13. Birthplace Howard Co. Md

MOTHER 14. Maiden name Mary E. Walters

15. Birthplace Howard Co. Md.

16. Informant Paul C. Cissel

Address 5210 Hampden Lane Bethesda Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-26-47 (month) (day) (year)

Cemetery or crematory Bethesda, Md.

Location Bethesda, Md.

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis Ave. Bethesda, Md.

19. May 26 1947 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 May 1947, at 4 50 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 March 1947, to 26 May 1947

and that I last saw h...er alive on 8 May 1947

Immediate cause of death Chronic myocarditis and myocardial degeneration

Due to Generally diff. arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION
2 yrs.

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thomas D. Watkins M. D.

M. D. or other

Address 2200 R.I. Ave. N.E. Washington 18 D.C. Date signed 26 May 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

04243

CERTIFICATE OF DEATH

Reg. Dist. No. 7324

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 years

Hospital, institution, or street address where death occurred: I

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Washington 20 DC (If outside city or town limits, write RURAL and give nearest town)

Street No. 5863 - Branch ave (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Eva Julia Comstock

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Harvey L. Comstock

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1879

8. AGE:

Years	Months	Days	If less than one day
67			..... hrs. ..... min.

9. Birthplace: Charles Co., Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: At home

FATHER — 12. Name: Joseph Milstead

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Julia Nash

MOTHER — 15. Birthplace: Maryland

16. Informant: Hilda Allen

Address: 5863 Branch Ave., S.E. DC 20

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8th 1947 (month) (day) (year)

Cemetery or crematory: Washington Natl. Cemetery

Location: Suitland, Maryland

18. Funeral director: Thomas F. Murray Funeral Home

Address: 2007 Nichols Ave S.E. Washington DC

19. May 6th 1947 (Date rec'd by registrar) Howard I. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1947, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1947, to May 6 1947, and that I last saw her alive on May 5 1947

Immediate cause of death	DURATION
Carcinoma of Rt lung	3 mo.
Due to: —	
Due to: —	
Other conditions: General Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: no Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) no

Means of injury — Injured at work?

23. SIGNATURE: Paul C. Van Natta M. D.

Address: Washington 19 DC Date signed: May 6 1947

M

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

04244

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred: Prince Georges General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No. 7426 Wisconsin Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hosie Sumpter Courtney
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Mary Thompson Courtney
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) August 21, 1921
8. AGE: Years 25 Months . Days — If less than one day ... hrs. ... min.
9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business A & P Stores
FATHER 12. Name Sumpter Courtney
13. Birthplace Virginia
MOTHER 14. Maiden name Lizzie Mason
15. Birthplace Virginia
16. Informant Mrs Elsie Harding
Address 4304 East West Highway Bethesda
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 11, 1947 (month) (day) (year)
Cemetery or crematory
Location Fredricksburg, Va
18. Funeral director F. Gasch's Sons
Address Hyattsville, Md.
19. 5/11 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 2 45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Fracture of skull Crushed chest	
Due to	
Other conditions Fracture of right femur	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-11-47
Where did injury occur? Beltsville P. G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Road
Manner of injury ... injured at work? Passenger in car that ran off road hitting tree
23. SIGNATURE [illegible] M. D. or other
Address [illegible] Date signed 5-11-47

04245

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hours
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Puerto Rico County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rurol, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Primitivo Rodriquez Cuevas

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): November 1, 1869
8. AGE: Years: 77 Months: 6 Days: 23 If less than one day: hrs. min.
9. Birthplace: Puerto Rico
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Jose Rodriquez
13. Birthplace: Peurto Rico
MOTHER 14. Maiden name: Maria DeLa Cruz Cuevas
15. Birthplace: Peurto Rico
16. Informant: Papers on the deceased
Address:
17. Transportation (Burial, cremation, or removal, Which?) Date thereof May 27, 1947 (month) (day) (year)
Cemetery or crematory: Arty Funeral Home
Location: New York city N. Y.
18. Funeral director: F Gaecha Sons
Address: Hyattsville Md.
19. May 27 1947 (Date rec'd by registrar) Mrs. Jas. Severe Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 19 47 at 6:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Hemorrhage and shock	
Due to: Compound depressed fracture of the skull	
Due to:	
Other conditions: Multiple lacerations of the face	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5/24/47
Where did injury occur? Route # 1 Muirkirk Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route # 1
Means of injury: Pedestrian struck by an auto.
Injured at work?

23. SIGNATURE: Deputy Medical Examiner James D. Boyd M. D. or other
Address: Forestville Md. Date signed: 5-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13c 95c 8

04246

Reg. Dist. No. 239

1. PLACE OF DEATH: County: Prince George

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 6 mo. - 29 da.

Hospital, institution, or street address where death occurred: Laurel Sanitarium

How long in hospital or institution? 1 yr. 6 mo. - 29 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. 6102 old Hanover Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Wm. Thomas Curran

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Annie Sheridan Curran

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 25 1857.

8. AGE:

Years	Months	Days	If less than one day
89 yr.	9	10	..... hrs. ..... min.

9. Birthplace: Baltimore - Md. (Town, county, and state)

10. Usual occupation: Type Setter

11. Industry or business:

FATHER
12. Name: John Curran.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Mary Knight
15. Birthplace: Maryland.

16. Informant: Hospital Records; Mother. Address: Laurel Sanitarium

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/2/47 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Taylor ave

18. Funeral director: Howard N. Blight Jr.

Address: 6909 Harford Road

19. 6/2 1947 (Date rec'd by registrar) A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 - 1947, at 11.45 - P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1947, to May 29 1947 and that I last saw h.. alive on May 29 - 1947

Immediate cause of death: Acute Cardiac Dilatation.

Due to: Arteriosclerosis.

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. Gradison - M.D. M. D. or other

Address: Laurel Sanitarium Date signed: May 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 F

04247

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos., 28 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 9 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3548 Minn. Ave., S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DAILEY, GRACE E.

3.(b) Social Security Number: 579-01-9047

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Dailey

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): November 24, 1906

8. AGE: Years	Months	Days	If less than one day
40	5	15	..... hrs. ..... min.

9. Birthplace: St. Mary's Co., Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - - - -

FATHER
12. Name: Joseph Cheseldine
13. Birthplace: St. Mary's Co., Maryland

MOTHER
14. Maiden name: Mary Mattinley
15. Birthplace: St. Mary's Co., Maryland

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/9/47 (month) (day) (year)

Cemetery or crematory

Location: Washington D.C.

18. Funeral director: Robt. S. Mattingly

Address: 131-11th St. S.E.

19. May 9 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1947, at 3'15 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/10 1946 to 5/9 1947 and that I last saw h.. alive on 5/9 1947

Immediate cause of death: pulmonary tuberculosis — DURATION: 38 mos.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 5/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

04248

Reg. Diat. No. 243

1. PLACE OF DEATH:

County Prince Georges

City or town Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

4317- Russell Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4317 Russell Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles William Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife Margaret J. Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1877

8. AGE: Years 70 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Philadelphia Pa (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Retired

FATHER 12. Name Charles W Davis

FATHER 13. Birthplace Delaware

MOTHER 14. Maiden name Mary Common

MOTHER 15. Birthplace Delaware

16. Informant Margaret Josephine Davis

Address 4317 Russell Ave, Mt Rainier

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22, 1947 (month) (day) (year)

Cemetery or crematory The Gate of Heaven Cemetery

Location Mt. Pleasant, Westchester Co., N.Y.

18. Funeral director Wm. J. Malley

Address 3200 - R.I. Ave. Mt. Rainier, Md.

19. May 21 1947 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1947 at 4 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did Injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Deputy medical Examiner

M. D. or other

Address Hyattsville Md Date signed 5-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180

CERTIFICATE OF DEATH

04243

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Fairmount Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 6200 Sheriff Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Fairmont Heights (If outside city or town limits, write RURAL and give nearest town)
Street No.: 6200 Sheriff Road (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Corine Davis
3. (b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 26, 1936
8. AGE: Years 10 Months Days If less than one day ... hrs. ... min.
9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business
FATHER 12. Name: Frank Jones
13. Birthplace: Unknown
MOTHER 14. Maiden name: Margaret Davis
15. Birthplace: Washington D.C.
16. Informant: Mrs. B. Bailey
Address: Fairmont Heights Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 13 1947 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Bladensburg Md
18. Funeral director: F. Gasch's Sons
Address: Hyattsville Md
19. 5/13 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1947 at 4 10 A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Shock	
Due to: General charring burns of the body.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5-11-47
Where did injury occur? Fairmont Heights P.G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: ~~house that burned~~
Deputy medical examiner
23. SIGNATURE [illegible] M. D. or other
Address: Forestville Md Date signed: 5-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

04250

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
6200 Sheriff Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6200 Sheriff Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Adams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife Lillie Adams
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) Feb 8, 1902

8. AGE: Years 45 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Columbia S. C. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Cement finishing

FATHER
12. Name Charles Adams
13. Birthplace South Carolina

MOTHER
14. Maiden name Margaret
15. Birthplace South Carolina

16. Informant Mrs. D. Bailey
Address Fairmount Hts. Md

17. (Burial, Removal, Which?) Burial Date thereof May 13 1947 (month) (day) (year)
Cemetery or crematory Methodist
Location Bladensburg Md
18. Funeral director F. Gaeck Sons
Address Hyattsville Md
19. 5/13/1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947 at 4:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
aed that I last saw h ... alive on ... 19...

	DURATION
Immediate cause of death Shock	
Due to Municipal clearing burns	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-11-47
Where did injury occur? Fairmount Hts (City or town) Prince Georges (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Horse kicked injured (how?)
Property municipal employee
23. SIGNATURE ... M. D. or other
Address Hyattsville Md Date signed 5-11-47

VS A15 9-45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04251

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180

CERTIFICATE OF DEATH

Reg. Dist. No. 231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Prince George
City or town: Fairmont Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 6200 Sheriff Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Fairmont Heights (If outside city or town limits, write RURAL and give nearest town)
Street No. 6200 Sheriff Road (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Tillie Davis

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Harry Davis
6.(c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.): 1887

8. AGE: Years 60 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home

FATHER
12. Name: Nath Simms
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs B. Bailey
Address: Fairmont Heights, Md

17. Buried (Burial, cremation, or removal, Which?) Date thereof: May 13 1947 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Bladensburg Md

18. Funeral director: F. Gasch Sons
Address: Hyattsville Md

19. 5/13 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1947, at 4:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Shock | DURATION

Due to: Accidental charring [illegible] of the body

Due to:

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5-11-47
Where did injury occur? Fairmont Hts P.G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: [illegible] house that [illegible] down Injured at work?
Deputy medical examiner

23. SIGNATURE [illegible] M. D. or other
Address: Forestville Md Date signed 5-11-47

VS A15 9-45-15M

04252

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 10 mos., 15 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 10 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1223 - 13th Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Dodd, Ernest B.

3.(b) Social Security Number: 579-05-6305

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Jeanette Thompson Dodd

8.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 19, 1910

8. AGE: Years	Months	Days	If less than one day
36	11	24	..... hrs. ..... min.

9. Birthplace: Brooklyn, New York
(Town, county, and state)

10. Usual occupation: Cab-Driver

11. Industry or business: - - - -

FATHER
12. Name: William Robert Dodd
13. Birthplace: Deleware

MOTHER
14. Maiden name: Unknown
15. Birthplace: Poland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13, 1947 (month) (day) (year)

Cemetery or crematory: Robert Church Yard

Location: Dover Del

18. Funeral director: J. Harry Williamson

Address: Fredericksburg Md

19. May 13 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1947, at 1 00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/27/44 1947 to 5/13 1947 and that I last saw him alive on 5/13 1947

Immediate cause of death	DURATION
pulm. Tuberculosis	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glen Dale Md. Date signed 5/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 0425 245

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred: Leland Memorial Hosp.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D.C. County: Wash.
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 322 Peabody N.W. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Miss Londa Downs
3.(b) Social Security Number

4. Sex: Fem
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Jan. 28, 1887
8. AGE: Years 60 | Months | Days | If less than one day ... hrs. ... min.
9. Birthplace: Beech Grove Kentucky (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: in War Dept.
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden name: Susan Colthorp
15. Birthplace
16. Informant: Mrs Nola Bumstead
Address: Bucyrus, Ohio
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Pr. Geo. Co., Md.
18. Funeral director: W. W. Chambers Co.
Address: 1400 Chapin St. N.W.
19. May 20 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947, at 11 30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1944, to May 18 1947; and that I last saw her alive on May 18 1947.
Immediate cause of death: Severe Intestinal Hemorrhage Severe — DURATION: on 5/14/47
Due to: Gen. Arteriosclerosis & Hypertension — 6 yrs.
Due to: Hypostatic Pneumonia — 3 days
Other conditions
(Include pregnancy within 3 months of death.)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Howard F. Moore Lind M. D. or other
Address: 28 Carroll Ave Takoma Park Md. Date signed: 5/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04254

93d

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Prince Georges
City or town: Berwyn Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph E. Dwyer.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Helen G. Dwyer
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): ~~72 yrs 3 mos 18 das~~ January 31, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	18	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Plasterer
11. Industry or business: Construction
FATHER 12. Name: Wm. J. Dwyer.
13. Birthplace: Md.
MOTHER 14. Maiden name: Johanna Brown
15. Birthplace: Md.
16. Informant: Ellen Krause
Address: Berwyn, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1947 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Laurel
18. Funeral director: DeWitt Donaldson
Address: Laurel, Md.
19. May 20th 1947 (Date rec'd by registrar) John L. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 19 47 at 9.30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May years 19 ..., to May 18 19 47
and that I last saw him alive on May 15 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	Several years
Due to Arterio-sclerosis	Several years
Due to Senility	Several year
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — — — —
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: W. Allen Griffith M. D. or other
Address: Berwyn Md Date signed: 5/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AN5 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

04255

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Chevrely, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 hrs.
Hospital, institution, or street address where death occurred:
Co. Geo. Genl Hosp.
How long in hospital or institution? 23 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Cottage city
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3718 37th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Eisentraut, Mr. Karl

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of ~~husband~~ or wife: A. M. Eisentraut
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Feb 27th 1882

8. AGE: Years	Months	Days	If less than one day
65			....hrs. ....min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: —
11. Industry or business
FATHER 12. Name: Johann Eisentraut
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: M. Sauer
MOTHER 15. Birthplace: Konigsberg, Bavaria, Germany.
16. Informant: Mrs. John Dahlmeier
Address: 3718-37th Ave. Cottage City Md. Un 0257
17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 19th 1947 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore Md.
18. Funeral director: Wm. J. Nalley
Address: 3200 Rhode Island Ave. Mt. Rainier Md.
19. 5/18 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-17 1947, at 12 55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1947; to May 17 1947 and that I last saw h. alive on May 16 1947

	DURATION
Immediate cause of death: Uremia	3 weeks ?
Due to: Hypertension & U-Renal Disease & Congestive Failure	Unknown
Due to:	
Other conditions: Chron. Arth. Ant. Cervicay	Unknown
Disease - Terminal Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: D. S. Clayman, M.D. M. D. or other
Address: Mt. Rainier, Md. Date signed: 5-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04256 170C

Reg. Dist. No. 231.

1. PLACE OF DEATH:
County Prince George
City or town Oxon Hill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Livingston Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State District of Columbia
City or town Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 3701- 4th Street S.E. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Evan Musgrave Elkins
3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Frances E. Elkins
6.(c) If alive, give age 24 years
7. Birth date of deceased (mo., day, yr.) March 7, 1923
8. AGE: Years 23 Months Days If less than one day ... hrs. ... min.
9. Birthplace Illinois (Town, county, and state)
10. Usual occupation Painter
11. Industry or business United Paint Co.
FATHER 12. Name Ernest R. Elkins
13. Birthplace Unknown
MOTHER 14. Maiden name Luna Musgrave
15. Birthplace Illinois
16. Informant Frances E. Elkins
Address 3701-4th St S.E, Washington D.C.
17. Burial. Date thereof May 19. 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland Md
18. Funeral director Robert Mattingly
Address 131-11 st SE Washington D.C.
19. 5/19 1947 Amanda Donovan (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947 at 11 25 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Crushed skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-18-47
Where did injury occur? Oxon Hill P.G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Livingston Rd
Means of injury Run over by car that was run over
Deputy Medical Examiner
23. SIGNATURE James I. Boyd M.D. or other
Address Forestville Md Date signed 5-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04257

932

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince George
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P. G.
City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Fleet

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Julia Fleet
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 3 1896
8. AGE: Years: 50 Months: 7 Days: 16 If less than one day: ..... hrs. ..... min.
9. Birthplace: Nottingham, Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Louis Fleet
13. Birthplace: Md.
MOTHER 14. Maiden name: Elizabeth Cuntroom
15. Birthplace: Md.
16. Informant: Eugene Fleet — R.F.D.
Address: 1519 11 st - N.W. Washington
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21 1947 (month) (day) (year)
Cemetery or crematory: Brookes
Location: Maylora, Md.
18. Funeral director: J.B. Johnson
Address: Landover Hills, Md.
19. May 20 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 19 47 at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 May 19 47 to 19 May 19 47 and that I last saw h.l.m. alive on 19 May 19 47

	DURATION
Immediate cause of death: Intracranial Hemmorhage - Cerebral.	2 days
Due to: Hypertensive Cardio Vascular Disease	Unk.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert B. Janney M.D. M. D. or other
Address: Upper Marlboro, Md. Date signed: 19 May 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS (A15) 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04258

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George

City or town: Collington - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Collington (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rose Fletcher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife: Joseph Fletcher

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years	Months	Days	If less than one day
69			....hrs. ....min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Westley Henry

13. Birthplace: Md

MOTHER — 14. Maiden name: Jane Fletcher

15. Birthplace: Md

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8 1947 (month) (day) (year)

Cemetery or crematory: White Marsh

Location: Collington, Md

18. Funeral director: E. Chaplis Sons

Address: Bladensburg Md

19. May 7 1947 (Date rec'd by registrar) Mrs. J. W. Yingling Registrar

MEDICAL CERTIFICATION 47

20. DATE OF DEATH: May 5 1947, at 24 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 5 1947

and that I last saw h[illegible] alive on May 4 1947

Immediate cause of death	DURATION
Cerebral Haemorrhage	4 days
Due to: Hypertension	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert S. McCreary M.D. M.D. or other

Address: 402 Main St. Laurel Md. Date signed: 5/5/47

M

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VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a 131b

04259

CERTIFICATE OF DEATH

Reg. Diat. No. 232

1. PLACE OF DEATH:
County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ellen Forbes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife James Forbes
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) 2 1894?

8. AGE: Years 63. Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Upper Marlboro, Md. (Town, county, and state)
10. Usual occupation At home
11. Industry or business

FATHER
12. Name George Bell
13. Birthplace Upper Marlboro, Md.

MOTHER
14. Maiden name Charity Chandler
15. Birthplace Upper Marlboro, Md.

16. Informant James Forbes
Address Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-12-47 (month) (day) (year)
Cemetery or crematory Mt. Carmel
Location Upper Marlboro, Md.

18. Funeral director Tolchie Brothers
Address Upper Marlboro, Md.

19. May 10 19 47 (Date rec'd by registrar) R. Ernest Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947 at 8:00 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 6 1947 to May 8 1947 and that I last saw h[illegible] alive on May 8 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Nephritis	4 yrs
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. Spencer M. D. or other
Address Upper Marlboro, Md Date signed 5-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04260

Reg. Dist. No. 242

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince Georges
City or town Oxon Hill Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Oxon Hill-Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6870 Oxon Hill Rd - Washington 20 DC
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Eliza Ellen Gant

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Negro	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
76	—	—	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jermiah Nuby
13. Birthplace Md.

MOTHER 14. Maiden name Mary Delaney
15. Birthplace Md.

16. Informant Julia Thomas
Address 6870 Oxon Hill, Rd.

17. Burial — Date thereof May 18- 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oxon Hill - Md
Location

18. Funeral director John T Rhines & Co.
Address 901 - 3rd St., S. W.

19. 5/14 1947 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 25 1947, to May 14 1947
and that I last saw her alive on May 13 1947

	DURATION
Immediate cause of death: Acute myocardial Degeneration	1 day
Due to: Cardiovascular Renal Disease and	unknown
Due to: Chronic Endocrinality	
Other conditions: Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Lee C. Van Hatten M. D. or Coroner
Address Washington 12 DC Date signed May 14, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93C

04261

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Berwyn Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 6 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8402 - 49 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edna Adele Gower

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Joseph James Gower
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1890

8. AGE: Years: 57 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Penna (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Thomas A. Hall
13. Birthplace: Pa

MOTHER
14. Maiden name: Cora Paul
15. Birthplace: Pa

16. Informant: Wm. Thomas Gower
Address: Berwyn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1947 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Washington Dc.

18. Funeral director: F Greche Sons
Address: Hyattsville Md.

19. May 30th 1947 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 MAY 1947 at 8 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 47 to MAY 19 47 and that I last saw her alive on 25 MAY 19 47

Immediate cause of death		DURATION
	Congestive Heart Failure	
Due to	Rheumatic Fever	20 yrs
	Hypertension	
Due to	Diphtheria - 20 yrs. ago (8/6/47 also) myocarditis	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. L. Etheigne M. D.
Address: Berwyn Md M. D. or other
Date signed: 30 May 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

04262

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince George's
City or town: Forestville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: Transient
Hospital, institution, or street address where death occurred: Marlboro Pike and Military Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County: Surrey
City or town: Mount Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #4
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: Paul Leon Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 9, 1923

8. AGE: Years: 23 Months: 5 Days: 0 If less than one day: hrs. min.

9. Birthplace: Surrey County, North Carolina (Town, county, and state)

10. Usual occupation: Buyer

11. Industry or business: Tobacco

FATHER
12. Name: Vern Hall
13. Birthplace: Surrey Co. N. C.

MOTHER
14. Maiden name: Pearl Jones
15. Birthplace: Mt Airy N. C.

16. Informant: Franklin Jones
Address: Mt Airy, N. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1947 (mo.) (day) (yr.)
Cemetery or crematory: Union Baptist Church Cem
Location: Mt Airy Rt. 4

18. Funeral director: Moody Funeral Home
Address: Mt Airy N. C.

19. May 9 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Fracture of skull Crushed Chest	
Due to:	
Other conditions: Fracture of left femur	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of: 5-9-47
Where did injury occur? Forestville (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Marlboro Pike
How did injury occur? Car that boy was injured in struck him
Deputy Medical Examiner
23. SIGNATURE: ... M. D. or other
Address: Forestville Md. Date signed: 5-9-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04263

1579

Reg. Dist. No. 2B1

1. PLACE OF DEATH

County: Prince Georges

City or town: Cardmore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Cardmore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cardmore Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen Harper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 26, 1946

8. AGE:

Years	Months	Days	If less than one day
1	4	27.	..... hrs. ..... min.

9. Birthplace: S. Carolina

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: E. B. Harper

FATHER — 13. Birthplace: S. Carolina

MOTHER — 14. Maiden name: Sara Fishburne

MOTHER — 15. Birthplace: S. Carolina

16. Informant: Institution Records

Address: Cardmore, Md.

17. (Burial, cremation, or removal. Which?) Shipped Date thereof: May 25 1947 (month) (day) (year)

Cemetery or crematory: Live Oak Cemetery

Location: Walterboro S. C.

18. Funeral director: F. Garcia Sons

Address: Hyattsville Md

19. 5/24/1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1947, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 21 1946, to May 22 1947 and that I last saw h.e alive on May 21 1947

Immediate cause of death: Congenital Malformation of Throat.

DURATION: birth

Due to:

Due to:

Other conditions: Mongoloid

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John J. Maloney M. D. or other

Address: Beverly-Hyattsville Date signed: 4-23-47

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83b

CERTIFICATE OF DEATH

04264 345
Reg. Dist. No.

1. PLACE OF DEATH:
County Prince George's
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4900 Somerset Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME BERNARD F. HENRY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 1864

8. AGE: Years 82 | Months | Days | If less than one day hrs. min.

9. Birthplace Springfield, Ky.
(Town, county, and state)

10. Usual occupation Contractor (retired)

11. Industry or business

FATHER
12. Name Francis B. Henry
13. Birthplace London England

MOTHER
14. Maiden name Ellen O'Kane
15. Birthplace Ireland

16. Informant Mrs H.C. Hutchison
Address 4900 Somerset Rd. Riverdale, Md.

17. Removal Date thereof May 27 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Lexington, Ky.

18. Funeral director W.W. Chambers Co.
Address Riverdale, Md.

19. May 27 1947 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1947 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 13 1947, to May 26 1947
and that I last saw him alive on May 24 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	2 days
Due to General arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L W Malin MD
M. D. or other
Address Riverdale, Md. Date signed 5-27-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04265

13b

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 4 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1811 - 6th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME JAMES ARTHUR HENSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 19, 1886

8. AGE: Years	Months	Days	If less than one day
60	10	26	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Retired Government Worker

11. Industry or business: Government Printing Office

FATHER 12. Name: George Thomas Henson

13. Birthplace: Maryland

MOTHER 14. Maiden name: Katherine Monroe

15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 17, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D. C.

16. Funeral director: Davis G. Brooks

Address: 1200 - Flo. Ave. N. W.

19. May 15, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 15 1947, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 10 1947, to MAY 15 1947 and that I last saw h...M... alive on MAY 15 1947

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	3 Mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glen Dale Md. Date signed: 5.15.47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1705 04266

CERTIFICATE OF DEATH

Reg. Dist. No. 231 232

1. PLACE OF DEATH:
County Prince Georges
City or town Upper Marlboro (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Fargo Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Melrose (If outside city or town limits, write RURAL and give nearest town)
Street No. 4213 - Brayton Place (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Thomas Hicks
3.(b) Social Security Number

4. Sex Male
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Alice Hicks
6.(c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) February 22, 1905
8. AGE: Years 42 Months Days If less than one day ... hrs. ... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business [illegible]
FATHER 12. Name William Hicks
13. Birthplace Maryland
MOTHER 14. Maiden name Josephine Owen
15. Birthplace Maryland
16. Informant Alice Hicks
Address 4213-Brayton Pl. Melrose, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 11, 1947 (month) (day) (year)
Cemetery or crematory Jarvis Funeral Home
Location Washington, D.C.
18. Funeral director F. Gasch's Sons
Address Hyattsville, Md.
19. 5/11 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947, at 11 30 A M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...
Immediate cause of death Hemorrhage and shock
Due to Crushed chest Rupture of heart
Due to
Other conditions
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations
Date of op.
Autopsy results No [illegible]
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-11-47
Where did injury occur? [illegible] Hts P. G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Fargo Rd
Means of injury Automobile accident Injured at work? (7/16/47 [illegible])
Deputy Medical Examiner
23. SIGNATURE [illegible] M. D. or other
Address [illegible] Md Date signed 5-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04268

830

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 616 Pr. George St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Veronica Husbands

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

B.(b) Name of husband or wife George Husbands
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 19 1877

8. AGE:

Years	Months	Days	If less than one day
69	11	21	..... hrs. ..... min.

9. Birthplace Manchester, Connecticut
(Town, county, and state)
10. Usual occupation Housemaid
11. Industry or business Home

FATHER
12. Name Timothy Hayes
13. Birthplace New York, N.Y.

MOTHER
14. Maiden name Bridget Murphy
15. Birthplace Ireland

18. Informant Mrs. Mary E. Patten
Address 616 Prince George St. Laurel

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 1947 (month) (day) (year)
Cemetery or crematory St. James Cemetery
Location Manchester, Conn.
18. Funeral director Dr. Hutt Donaldson
Address Laurel, Maryland

19. May 31 1947 M. Buscheau
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1947 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1947 to May 31 1947
and that I last saw h-- alive on May 30 1947

	DURATION
Immediate cause of death Cerebral apoplexy	Week ill
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W B [illegible] M. D. or other
Address [illegible] Date signed 5/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

39c

04269

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince Georges Co.
City or town Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Leland Memorial Hosp
How long in hospital or institution? 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. of Col. County
City or town WASHINGTON D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2714 29th Pl S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CHARLES ERNEST KASISCHKE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Martha Schroder
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1876

8. AGE: Years 70 | Months 8 | Days 18 | If less than one day hrs. min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Car Inspector
11. Industry or business Detroit Machine R.R.
FATHER 12. Name August Kasischke
13. Birthplace Germany
MOTHER 14. Maiden name Fredericke
15. Birthplace Germany
16. Informant Ruth E. Mayer
Address 2714 29th St S.E. Wash D.C.
17. Interment (Burial, cremation, or removal. Which?) Date thereof May 16 1947 (month) (day) (year)
Cemetery or crematory
Location Eastern Branch
18. Funeral director Jas. Fowler's Sons
Address 1756 Penna Ave N.W.
19. May 16 1947 (Date rec'd by registrar) James Sever Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-15- 1947, at 9:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-7- 1947, to 5-15- 1947
and that I last saw him alive on 5-14- 1947

	DURATION
Immediate cause of death Rocky Mountain Spotted Fever	6 days
Due to	
Due to	
Other conditions Bronchiopneumonia	5 days

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clarence L. Purdy, M.D. M. D. or other
Address 1503 Good Hope Rd. S.E., D.C. Date signed 5-15-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 0427 345

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 7 days
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or Institution? 2 months 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1335 Quebec St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Miss Louise May Kephart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 29, 1873

8. AGE: Years	Months	Days	If less than one day
73	8	29	..... hrs. ..... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual occupation ?
11. Industry or business ?

FATHER
12. Name John Lewis Kephart
13. Birthplace Maryland

MOTHER
14. Maiden name Emily Virginia Moler
15. Birthplace Jefferson Co. W. Va.

16. Informant Chart.

Address .....
17. Burial, cremation, or removal. Which? Burial Date thereof May 29 1947 (month) (day) (year)
Cemetery or crematory Glenwood Cemetery
Location Forest Road & Bulland Rd

18. Funeral director Harry L. Slye
Address 1009-H-Street, N.W. - Wash., D.C.

19. May 29 1947 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1947, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to May 28 1947 and that I last saw h.. alive on May 24 1947

Immediate cause of death	DURATION
Carcinoma of colon	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Henry A. Radley M. D. or other
Address 1252 Euclid St. Date signed May 28 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, Institution, or street address where death occurred:
Prince George General Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: PRINCE GEORGE
City or town: SEAT PLEASANT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6619 - CENTRAL AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: KLOCK - JAMES G.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: DAISY KLOCK
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JUNE 18 1897

8. AGE: Years	Months	Days	If less than one day
49	10	23	hrs. min.

9. Birthplace: SEAT PLEASANT MD.
(Town, county, and state)
10. Usual occupation: SUPT. OF ASH COLLECTION
11. Industry or business: D. OF C.
FATHER 12. Name: WM. G. KLOCK
13. Birthplace: N.Y.
MOTHER 14. Maiden name: NETTIE WALKER
15. Birthplace: D.C.
16. Informant: WIFE -
Address: 6619 - CENTRAL - ST. PLEASANT
17. removal (Burial, cremation, or removal. Which?) Date thereof 5/11/47 (month) (day) (year)
Cemetery or crematory: Wash D C
Location:
18. Funeral director: J. Wm. Lee's Sons Co
Address: 660 - 4 St. N.E - Wash D.C.
19. May 11 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 11 1947, at 10 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1947, to May 11 1947
and that I last saw him alive on May 11 1947

Immediate cause of death	DURATION
Coronary Occlusion	4 hours
Pneumonia	19 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D. or other
Address: Capitol Hgts, Md Date signed 5/11/47

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45.15M

0174-W

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04272

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27rd

Hospital, Institution, or street address, where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Talbott Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hattie Lee Krauser

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widowed

6.(b) Name of husband or wife Henry J. Krauser

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 12 1882

8. AGE: Years	Months	Days	If less than one day
64	7	15	..... hrs. ..... min.

9. Birthplace Dutton Md (Town, county and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name Samuel Harding

13. Birthplace Md.

MOTHER 14. Maiden name Martha Poole

15. Birthplace Md.

16. Informant Mrs. Mary Cooney

Address 325 Talbott Ave Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 30 1947 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Burtonsville Md

18. Funeral director Beth Donaldson

Address Laurel Md.

19. May 29 1947 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27- 1947 at 6.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1947, to May 27 1947 and that I last saw her alive on May 27 1947

Immediate cause of death	DURATION
Cerebral Haemorrhage	4
Due to Hypertension	3 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D B Redmond M. D. or other

Address Laurel Date signed 6/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04273

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Fairmont Height
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 6200 Sheriff Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Fairmount Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6200 Sheriff Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hartley Lee

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Wilson Lee

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE: Years 41 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Leroy Brewer
13. Birthplace: Unknown

MOTHER
14. Maiden name: Lillie Lyons
15. Birthplace: Maryland

16. Informant: Mrs B. Bailey
Address: Fairmont Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13 1947 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Bladensburg Md

18. Funeral director: F. Gasch's Sons

Address: Hyattsville Md

19. 5/13 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947 at 4:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19.... to .... 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death: Shock

Due to: Universal charring burns to the body

Due to:

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations .... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 5-11-47

Where did injury occur? Fairmount Ht. P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: [illegible] Injured at work:

Deputy medical examiner

23. SIGNATURE [illegible] M. D. or other

Address: Forestville Md Date signed 5-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

04274

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 6700 Sheriff Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6700 Sheriff Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wilson Lee
3.(b) Social Security Number

4. Sex Male
5. Color or race Colored
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Dolly Lee
6.(c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) 1916
8. AGE: Years 31 Months Days If less than one day ... hrs. ... min.
9. Birthplace Montgomery County, Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Sewell
FATHER 12. Name Howard Lee
13. Birthplace Maryland
MOTHER 14. Maiden name Lillie Dowes
15. Birthplace Maryland
16. Informant Mrs B. Fuller
Address Fairmont Heights Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1947 (month) (day) (year)
Cemetery or crematory Methodist
Location Bladensburg Md
18. Funeral director F. Gasch & Sons
Address Hyattsville Md
19. 5/13 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1947 at 4:00 P M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death Shock — DURATION
Due to Extensive burns of the body
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5-11-47
Where did injury occur? Fairmont Hts P. G. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury House that burned
Deputy medical examiner
23. SIGNATURE [illegible] M. D. or other
Address [illegible] Md Date signed 5-11-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45C

04275

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Six days - 13½ hrs.
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? Six days and 13½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Mt Ranier
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3708 - 35th Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry E. Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 9, 1869

8. AGE: Years	Months	Days	If less than one day
78	4	13	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Retired - Pharmacist
11. Industry or business

FATHER
12. Name: Thomas D. Lewis
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Aimee L. Moore
15. Birthplace: Washington, D. C.

16. Informant: Mrs. Wm. D. Bergman (daughter)
Address: 3620 - 16th St., N. W., Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24 - 47 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington DC
18. Funeral director: A H Hines Co
Address: 2901 - 14th St NW

19. 5/22 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 - 22 1947, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 - 15 1947, to 5 - 22 1947 and that I last saw him alive on 5 - 22 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Cardiac Asthma	1 week
Due to: Hypertensive cardio	
Vascular Disease & Arteriosclerosis	5 years
Due to:	
Other conditions: Congestion in Lungs	2 years
Bronchitis	5 years +

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Chronic cardiac
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W Bruce Jones M.D. (M. D. or other)
Address: Mt Rainier Md Date signed: 5-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04276

55e

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, Institution, or street address where death occurred:
Prince Georges Hospital
How long in hospital or institution? 10 hours - 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas H. Lewis III

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 | Months | Days | If less than one day hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Thomas H. Lewis
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Ward
15. Birthplace Maryland

16. Informant Mrs. Katherine Lewis
Address 5606 - 36th Pl. Hyattsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1947 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster Maryland

18. Funeral director The E. H. Hines Co.
Address 2901-14th St. N.W. Washington D.C.

19. May 14 1947 (Date rec'd by Registrar) Mrs. Jas. Severe Registrar
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1947, at 8 40/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1947, to May 14 1947 and that I last saw him alive on May 13 1947

Immediate cause of death	DURATION
Lymphosarcoma, generalized	2 yrs.
Due to	
Due to	
Other conditions Bronchopneumonia	2 days.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel J. N. Sugar M.D.
M. D. or other
Address Mt. Rainier, Md. Date signed May 14 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04277

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 8 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 - 8th St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MARIE LOVING

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Sidney A. Loving
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1919

8. AGE: Years	Months	Days	If less than one day
28	1	8	hrs. min.

9. Birthplace: Bristol, Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: - - -

FATHER
12. Name: William A. Pendergrass
13. Birthplace: Virginia

MOTHER
14. Maiden name: Pollan Crusenberry
15. Birthplace: Virginia

16. Informant: Donna Hudson, Sister
Address: 100 - 8th St., N. E.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 20 1947 (month) (day) (year)
Cemetery or crematory:
Location: Wash. D.C.

18. Funeral director: Martin W Kysong Co
Address: 1300 N St NW.

19. May 20, 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 20 1947 at 11 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 5 1946, to MAY 20 1947
and that I last saw h.e.r. alive on MAY 20 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D., M. D. or other
Address: Glenn Dale Md. Date signed 5-20-47

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-P)

CERTIFICATE OF DEATH

04278

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Chesapeake Beach, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EVA W. MACKAY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): November 22, 1870

8. AGE:

Years	Months	Days	If less than one day
76	6	9	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business
12. FATHER — Name: Henry Blamey Woodfield
13. FATHER — Birthplace: Texas
14. MOTHER — Maiden name: Mary Ellen Cox
15. MOTHER — Birthplace: D. C.
16. Informant: Mrs. Catherine Theodore (niece)
Address: 4726 Woodberry Rd., Riverdale, Md.
17. Cremation (Burial, cremation, or removal: Which?) Date thereof June 2, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Md
18. Funeral director: F. Gracia's sons
Address: Hyattsville Md.
19. 6/2 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31, 1947, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5 May 1947 to 31 May 1947 and that I last saw her alive on 31 May 1947

Immediate cause of death: Acute Hypostatic Pulmonary congestion & secondary to Chr infected ulcer-Left Leg

DURATION

Due to: Ac Cardiac dilation & fatty infiltration
Due to: Chronic nephritis
Due to: Chr passive congestion
Other conditions: of liver & spleen

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. L. Etienne, M.D. M. D. or other
Address: Berwyn, Md. Date signed 31 May 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 04279

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 9 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 Florida Avenue, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARTHA ELLEN MALLORY

3.(b) Social Security Number: 226-26-4159

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Pete Mallory

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): March 4, 1920

8. AGE: Years	Months	Days	If less than one day
27	2	2	hrs. min.

9. Birthplace: Leesburg, Virginia
(Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business: - - -

FATHER
12. Name: Arthur Murray
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Virginia

16. Informant: Deceased

Address

17. removal (Burial, cremation, or removal. Which?) Date thereof: May 6, 1947 (month) (day) (year)

Cemetery or crematory: Washington, D.C.

Location

18. Funeral director: L. E. Murray & Son

Address: 1337-10th St. N.W., Washington, D.C.

19. May 6, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6th 1947, at 1 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1946, to May 6th 1947, and that I last saw her alive on May 6th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yr 1 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: May 6, 1947

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the addition of sex of child is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04280

159

FILM No. G 110 JUN 10 1947 **CERTIFICATE OF DEATH**

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince George

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hr 40 mins

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Delivered home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prince Georges

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Baby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	—

6.(b) Name of ~~husband or wife~~ mother: Birdie Marshall

6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): May 30 - 1947

8. AGE: Years | Months | Days | If less than one day: 2 hrs. 40 min.

9. Birthplace: Laurel, Prince George. Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Joseph Nicholson

FATHER — 13. Birthplace: High Ridge - maryland

MOTHER — 14. Maiden name: Birdie Marshall

MOTHER — 15. Birthplace: Laurel, maryland.

16. Informant: Birdie Nicholson

Address: ~~High Ridge~~ Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31 1947 (month) (day) (year)

Cemetery or crematory: Muirkirk

Location: Muirkirk Md

18. Funeral director: Ridgely Selby

Address: 401 Wash Ave Laurel Md

19. May 31 19 47 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/30/47 19 at 5a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/30/47 19 for 5/30/47 19

and that I last saw h[illegible] alive on 5/30/47 19

Immediate cause of death: premature birth	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. M. Warren M. D. or other

Address: Laurel Md Date signed: 5-30-47

(I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

0428

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9.45-15M

1. PLACE OF DEATH:
County Prince Geo
City or town Laurel Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, Institution, or street address where death occurred: Prince Hospital
How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md County Pr Geo
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 333 Monty Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lena Etta Marlow

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Francis L. Marlow
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Sept 19 - 1875

8. AGE: Years 71 | Months 6 | Days 14 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Laurel Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Thos H. Baldwin
13. Birthplace
MOTHER 14. Maiden name: Stachia Bounds
15. Birthplace: Maryland
16. Informant: Mattie Marlow
Address: Laurel Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5 - 1947 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Laurel Md
18. Funeral director: DeWitt Donaldson
Address: Laurel Md.
19. May 5 - 1947 M. Beasheare Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947 at 7:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-4 1947 to 5-2 1947 and that I last saw h[illegible]R alive on 5-2 1947

Immediate cause of death: Coronary Occlusion — DURATION: ____

Due to: Arterio Sclerosis — DURATION: 3 Yrs.

Due to: Hypertension — DURATION: 8 Yrs.

Due to: Arteriosclerosis — DURATION: 8 Yrs.

Other conditions: Ovarian Cyst. — DURATION: 1 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE J. M. Warren M.D. M. D. or other
Address Laurel Date signed 5/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-6

04282

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Pr. Geo.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 102 Days
Hospital, Institution, or street address where death occurred:
Pr. Geo. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5313 Taylor Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mc Cann, Mr. Wesley M.

3.(b) Social Security Number: 577-26-9570

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mary Rebecca McCann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 24, 1875.

8. AGE: Years	Months	Days	If less than one day
71	-	-	....hrs. ....min.

9. Birthplace: N.C. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Safeway Stores

FATHER
12. Name: Francis Mc Cann
13. Birthplace: N.C.

MOTHER
14. Maiden name: Lydia
15. Birthplace: N.C.

16. Informant: C. E. McCann
Address: Riverdale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md

18. Funeral director: E. Grecki Sons
Address: Hyattsville Md.

19. 5/23 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-21 1947 at 12 15/A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-7 1947 to 5-21 1947 and that I last saw h.../.. alive on 5-20- 1947

Immediate cause of death	DURATION
Uremia	
Due to Ca of Prostate	
+ Edymoid	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Floyd W Hughes MD (M. D. or other)
Address: Prince George General Hosp. Date signed: 5-21-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04283

61

Reg. Diat. No. 541

1. PLACE OF DEATH:

County: Prince Georges

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred: Brown Station Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Brown Station Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Julia Beall Mills

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Leonard Mills

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 11, 1888

8. AGE: Years: 59 Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Robert Bowen

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Betty Pennington

15. Birthplace: Maryland

16. Informant: Leonard Mills

Address: Forestville, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 29, 47 (month) (day) (year)

Cemetery or crematory:

Location: Washington D. C.

18. Funeral director: Robert J. Mason

Address: 2500 Nichols Ave. S. E.

19. May 29 1947 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1947, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardio-vascular-renal disease	
Due to:	
Other conditions: Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner James D. Bond M. D. or other

Address: Forestville Md. Date signed: 5-29-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04284

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Bowie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland, County: Prince Georges

City or town: Bowie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ethel Lee Milton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife: Lloyd Milton

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): June 4, 1910

8. AGE: Years: 36 | Months: 0. | Days: | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own Home

FATHER 12. Name: Will Stevens

13. Birthplace: Philadelphia Pa

MOTHER 14. Maiden name: Nellie C Bowles

15. Birthplace: Virginia

16. Informant: Donald Lee Wilkerson

Address: Stevensburg Va

17. (Burial, cremation, or removal (Which?)) Date thereof: (month) 5 (day) 5 (year) 47

Cemetery or crematory: West Funeral Parlors

Location: Culpeper Virginia

18. Funeral director: H. Gaschi Sons

Address: Hyattsville, Md.

19. May 5 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1947 at 2.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage as a result of	
Due to Gun shot wound of head and chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: 5-3-47

Where did injury occur? Bowie (City or town) Prince Georges (County) Md (State)

Injured at home, farm, Industry, public place (where?)

Manner of injury: Shot with shotgun Injured at work?

Deputy medical Examiner

23. SIGNATURE: ... M. D. or other

Address: Forestville Md Date signed: 5-5-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04285

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Pro Geo Co
City or town Landover Hills Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pro Geo Co
City or town Landover Hills Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4219 - 71 Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ella C. Moore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Eugene Moore
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 18, 1875

8. AGE: Years 72 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Donald R. Moore (son)
Address 4219 - 71 ave Landover Hills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23. 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location suitland Md.

18. Funeral director F Gracia sons
Address Hyattsville Md.

19. 5/28 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19. 1947, at 11.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1935 to May 19 1947 and that I last saw her alive on April 21 1947

Immediate cause of death	DURATION
acute heart failure	few minutes
Due to chronic cardiac decompensation	5 yrs
Due to arteriosclerotic heart disease	9 yrs
Other conditions carcinoma of right breast (Include pregnancy within 3 months of death)	1 yr.

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE Daniel B. Washington M.D.
M. D. or other
Address 6234 Fa Ave Date signed 5/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/21/47 Coroner was notified and
he approved signing of this
certificate. D S Darlington M D

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04286 234

CERTIFICATE OF DEATH

Reg. Dist. No. 96

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince Georges
City or town: Clinton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Clinton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN R. MOORE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Moore
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13th 1873

8. AGE:

Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Forestville, Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: St. Elizabeth's Hospital

FATHER
12. Name: Christopher Moore
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Richard C. Moore
Address: Clinton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16th 1947 (month) (day) (year)
Cemetery or crematory: Christ Episcopal Church Cemetery
Location: Clinton, Maryland

18. Funeral director: Thomas F. Murray Funeral Home
Address: 2007 Nichols Ave, S.E. D.C.

19. May 14 19 47 (Date rec'd by registrar) Howard I. Beall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 19 47 at 7 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 19 47 to May 13 19 47 and that I last saw h.im alive on May 13 19 47

	DURATION
Immediate cause of death: Cerebral Hemorrhage	12 hrs
Due to: General Arterio-Sclerosis	Unknown
Due to: —	
Other conditions: Chronic Multiple arthritis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: Paul O. Van Natta M. D. or other
Address: Washington 1, D.C. Date signed: May 14 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04287

Reg. Diat. No. 239

1. PLACE OF DEATH:

County Prince George

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
405 Prince George St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. 405 Prince George
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cora Lee Morrison

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Claude Morrison

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 24, 1875

8. AGE: Years 71 | Months 9 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Geo F Fyddard
13. Birthplace Md

MOTHER
14. Maiden name Susannia M Watkins
15. Birthplace Md

16. Informant Mrs. Eliz Windham
Address Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1947 (month) (day) (year)

Cemetery or crematory Levy Hill

Location Laurel Maryland

18. Funeral director Hewitt Donaldson

Address Laurel Maryland

19 May 26 19 47 (Date rec'd by registrar) M. Bradshaw Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1947 at 7 30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10 15 1946, to 5-25-47 1947

and that I last saw h[illegible] alive on 5-25-47 1947

	DURATION
Immediate cause of death Apoplexy	1 hr.
Due to Hypertension	6 yrs
Due to R.V.D. Hypertrophy Arteriosclerosis	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B O'Hare M. D. or other

Address Laurel Md Date signed 5-26-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 04288

Reg. Diat. No. 242

1. PLACE OF DEATH:
County ~~6288 Allentown Rd.~~ Pr. Geo.
City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 6288 Allentown Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. Geo.
City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6288 Allentown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MAUD E. MORRISON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Alfred R. Morrison
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 19, 1894

8. AGE: Years	Months	Days	If less than one day
52			..... hrs. ..... min.

9. Birthplace: Caroline County, Virginia
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Oscar Baylor
13. Birthplace: Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Virginia

16. Informant: Alfred Morrison
Address: 6288 Allentown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7- 1947 (month) (day) (year)
Cemetery or crematory Cemetery
Location Camp Springs - Md -
18. Funeral director John T. Plumer & Co.
Address 901 - 3rd St., S. W.

19. May 5 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 5.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to May 4 1947
and that I last saw her alive on May 1 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation with Oedema	4 days
Due to Cardio-Vascular Disease	
Due to	
Other conditions Anaemia and Hypotension	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Luther J. Scott M. D. or other
Address 2504 Nicholson St. D.C. Date signed 5-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

04289

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
5300 - O Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5300 - O Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Peter Murray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Jemima Cent Murray
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1862

8. AGE: Years 85 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Horticulturist

11. Industry or business Retired

MOTHER FATHER
12. Name John Murray
13. Birthplace Scotland
14. Maiden name Margaret Rankin
15. Birthplace Scotland

16. Informant Ellen M. Hurley
Address 5300 O Street, Hyattsville, Md.

17. Burial (Burial, cremation, removal. Which?) Date thereof May 16/47 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery, Hyattsville, Md.
Location Plymouth Plot
18. Funeral director D. H. Chamberlain & Co.
Address 2717-11 St. N.W.

19. May 16 1947 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Deputy medical examiner M. D. or other
Address Westville Md. Date signed 5-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04290

93d

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 245

1 PLACE OF DEATH
County Leland Memorial Hospital
Village or City Riverdale, Md. (No.) Prince Georges Co. St.: Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mr. B. F. Myers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, X OR DIVORCED (Write the word)

6 DATE OF BIRTH: March 8, 1869 (Month) (Day) (Year)

7 AGE: 78 yrs. 1 mos. 28 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Retired Physician of U.S.
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: William Coyle Myers

11 BIRTHPLACE OF FATHER (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Catherine Dalphin Kennedy

13 BIRTHPLACE OF MOTHER (State or Country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Myers
(Address) 7005 F. St. Seat Pleasant Md.

15 Filed May 7 1947 James Seery Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 7, 1947 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 21st 1945 to May 7, 1947 that I last saw h[illegible] alive on May 7, 1947 and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH * was as follows:
Coronary Thrombosis
(Duration) yrs. mos. 1 ds.
Contributory Secondary: Hypertension cardiac disease
(Duration) [illegible] mos. ds.

(Signed) Thomas J. Bradley M. D.
192 (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Reeent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Formar or usual residence

19 PLACE OF BURIAL OR REMOVAL: Wash D.C. Congressional Cemetery

DATE OF BURIAL: May 12, 1947

20 UNDERTAKER: Perry & Walsh

ADDRESS: 510 - C St. NE.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

04291

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, institution, or street address where death occurred:
Pr. Geo. Gen'l
How long in hospital or institution? 23days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4901 Emerson St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nees, Mr. Bernard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Agnes E. Nees
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1885

8. AGE: Years	Months	Days	If less than one day
62			....hrs. ....min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: Linotype Operator
11. Industry or business:
FATHER 12. Name: Martin Nees
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace: "
16. Informant: mrs agnes E. Nees
Address: Hyattsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md
18. Funeral director: E Gaeck's sons
Address: Hyattsville Md.
19. 6/2 19 47 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-31- 19 47, at 12.45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 47 to May 31 19 47 and that I last saw h... alive on May 30 19 47

Immediate cause of death	DURATION
Congestive Heart failure	10 days
Due to: Arteriosclerotic cardio-	4 yrs
vascular renal disease	
Due to:	
Other conditions: Hemiparesis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Ronald S. Tieslau M.D. (M. D. or other)
Address: 30 39-11 St. N.W. Wash DC Date signed: 5-31-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04292

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 L

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 1 mo., 17 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 1 mo., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1432 - 18th St., S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME CECIL E. NEWMAN

3.(b) Social Security Number 250-01-9172

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Lillie J. Newman
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): January 3, 1888

8. AGE: Years	Months	Days	If less than one day
59	4	12	..... hrs. ..... min.

9. Birthplace: Knoxville, Tennessee
(Town, county, and state)

10. Usual occupation: Ex. R. R. Man

11. Industry or business: - - -

FATHER
12. Name: William F. Newman
13. Birthplace: Tennessee

MOTHER
14. Maiden name: Lou Ellen Douglas
15. Birthplace: Tennessee

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5 · 19 · 47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: md
18. Funeral director: W. W. Chambers Co.
Address: 517 - 11th St. S.E.

19. May 15, 1947 (Date rec'd by Registrar) Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 15, 1947, at 10 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-27-1946 to MAY 15 1947
and that I last saw h.. alive on MAY 15 1947

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 22 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 5.15.47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

04293

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Mos.
Hospital, Institution, or street address where death occurred: Davis Nursing Home
How long in hospital or institution? 7 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. Davis Nursing Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARTIN OTIS PAUL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 6, 1946

8. AGE: Years: 0 | Months: 8 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Martin A. Paul P.H.D.

13. Birthplace: N. Y.

MOTHER 14. Maiden name: Genevieve N. Wells

15. Birthplace: N. Y.

16. Informant: Martin A. Paul

Address: 409 June St. Endicott, N. Y.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: May 20 (month) (day) 1947 (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Md

18. Funeral director: Nelson Walters

Address: 505 Washington Blvd. Laurel, Md.

19. 5-19 (Date rec'd by registrar) 1947 Cora E. Wachter Registrar
Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947, at 6:11 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/5 1946 to 5/18 1947 and that I last saw h[illegible] alive on 5/18 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to: Meningitis Cerebrospinal	
Due to: Bronchial Pneumonia	5 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. M. Warren M.D.
M. D. or Other
Address: Laurel Date signed: 5/19/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

04294

CERTIFICATE OF DEATH

Reg. Dist. No. 237

1. PLACE OF DEATH:
County: Prince George's
City or town: Ceder Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred:
In front of 6302 K Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5906 Kalk Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward L. Payne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Augustine Payne
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 8, 1922.

8. AGE: Years	Months	Days	If less than one day
24			..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Stock clerk
11. Industry or business: Department store

FATHER
12. Name: Edward J. D. Payne
13. Birthplace: D. C.

MOTHER
14. Maiden name: Geraldine Kirkman
15. Birthplace: Unknown

16. Informant: Olelia O. Payne
Address: 5906 Kalk Street, Fairmont Hts, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 7, 1947 (Month) (day) (year)
Cemetery or crematory: Washington Funeral Home
Location: 467 N st. N.W. Washington D.C.

18. Funeral director: L. Kosché sons
Address: Hyattsville Md.

19. 5/7 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1947 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Gun shot wound of the chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 5/6/47
Where did injury occur? Ceder Heights (City or town) P. G. (County) Md. (State)
Injured at home, farm, Industry, public place (where?) Street
Means of injury: Shot in the chest Injured at work? No

23. SIGNATURE: Deputy Medical Examiner
M. D. or Coroner
Address: Forestville, Md Date signed: 5/6/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04295

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Prince Georges
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yr. 11 mo. 27 da.
Hospital, Institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 16 yrs. 11 mo. 27 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Blanche M Penfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 19 1877.

8. AGE: Years	Months	Days	If less than one day
70	3	13	..... hrs. ..... min.

9. Birthplace American Indiana
(Town, county, and state)

10. Usual occupation None -

11. Industry or business

FATHER 12. Name Wm L. Penfield -

13. Birthplace Lenawee Co. Mich.

MOTHER 14. Maiden name - Luba Walter -

15. Birthplace - Michigan.

16. Informant Records in Sanitarium

Address .....

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 2 - 1947 (month) (day) (year)

Cemetery or crematory Ft Lincoln. DC

Location .....

18. Funeral director Jos. Gawler's Son

Address 1756 Pa Ave N W.

19. May 2, 1947 (Date rec'd by registrar) Wm. D. Richards Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 - 1947, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 - 1930 to May 2 1947 and that I last saw h.. alive on May 2 1947

Immediate cause of death Coronary Thrombosis

DURATION 1 hr.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Jessel C. Coggin M. D. or other

Address Laurel, Md. Date signed 5/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

137 04296

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 3 mo's., 4 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 2 yrs., 3 mo's., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 931- E. St., S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3.(a) FULL NAME: EARL T. PETERSON

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Helen Peterson

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): Oct. 23, 1914

8. AGE:

Years	Months	Days	If less than one day
32	7	2	..... hrs. ..... min.

9. Birthplace: Bluemont, Va.
(Town, county, and state)

10. Usual occupation: machinist, Govt. Printing office

11. Industry or business: –

FATHER
12. Name: Thomas H. Peterson
13. Birthplace: Bluemont, Va.

MOTHER
14. Maiden name: Anita Cooper
15. Birthplace: Bluemont, Va.

16. Informant: deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-26-47 (month) (day) (year)

Cemetery or crematory: To Wash DC

Location

18. Funeral director: Barnes & Matthews
Address: 614-4" St. S.W. Wash. 4. D.C.

19. May 25, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25th 1947 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 20th 1945, to May 25th 1947
and that I last saw him alive on May 25th 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs 3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David Lee Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: May 25, 1947

M

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

64297

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1572

CERTIFICATE OF DEATH

Reg. Diat. No. 245 230

1. PLACE OF DEATH:
County Prince George's
City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4-E Hill Side Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME RICHARD HENRY PLACKETT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20, 1947

8. AGE: Years	Months	Days	If less than one day
	2	25	hrs. min.

9. Birthplace Prince George's Hosp. Md. (Town, County, and state)
10. Usual occupation Infant
11. Industry or business
FATHER 12. Name Arthur Plackett
13. Birthplace New York State
MOTHER 14. Maiden name Margaret Givins
15. Birthplace New York State
16. Informant Arthur Plackett
Address 4-E Hill Side Rd. Greenbelt, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1947 (month) (day) (year)
Cemetery or crematory Ft. Lincoln Cemetery,
Location Washington, D.C.
18. Funeral director W. W. Chambers Co.
Address Riverdale, Md.
19. May 16 1947 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1947, at 2:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Acute Pulmonary edema	
(b) Decompensation heart failure	
(c)	
Due to (a) Patent foramen ovale	
Other conditions Enlarged thymus and mesenteric lymphatic glands	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner Edward R. Ford M. D. or other
Address Ft. Foxhall, Md. Date signed 5-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04298 B

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Davis Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 923 Horner's Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: JOE ANN L. PRESTI

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 1, 1945

8. AGE: Years	Months	Days	If less than one day
2	3	19	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Joseph J. Presti
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Lucy Nelson
15. Birthplace: Baltimore, Md.

16. Informant: Mr. Joseph J. Presti
Address: 923 Horner's Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/21/47 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 5/21 19 47 Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Apr. 17 1947 to May 20 1947 and that I last saw her alive on May 9 1947

	DURATION
Immediate cause of death: Encephalitis	1 yr
Due to: Meningitis	1 yr
Due to:	
Other conditions: Cardiac Failure, General Paralysis of the Insane	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Warren M.D. M. D. or other
Address: Laurel Date signed: 5-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

04299

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Prince George's
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
37 H Ridge Rd., Greenbelt, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's.
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 37 H. Ridge Rd.,
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME
ANDREW PAUL RESNISKY

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Sophia Resnisky
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1864

8. AGE: Years	Months	Days	If less than one day
83	3	22	hrs. min.

9. Birthplace: Czechoslovakia
(Town, county, and state)
10. Usual occupation: Textile worker (retired)
11. Industry or business

FATHER
12. Name: Jacob Resnisky
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden name: Anna Nederoscik
15. Birthplace: Czechoslovakia

16. Informant: Mrs. Myrtle Resnisky
Address: 37 H Ridge Rd., Greenbelt, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16, 1947 (month) (day) (year)
Cemetery or crematory: St. Marys, Unionville, Conn.
Location: Unionville, Hartford Cy, Conn.
18. Funeral director: W. W. Chambers Co.
Address: Riverdale, Md.

19. May 14 1947 (Date rec'd by registrar) Mrs. Jas. Devere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 19 47 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel J. Long Deputy medical examiner M. D. or other
Address: Hyattsville, Md. Date signed: 5-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-415 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

137 04300

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale (Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 4 mo's, 25 days

Hospital, institution, or street address where death occurred:
Glenn Dale San.,

How long in hospital or institution? 8 years, 4 mo's, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6703- Georgia Ave., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: -

3.(a) FULL NAME: RICHARDS, JOHN O.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ethel C. Richards

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): February 11, 1870

8. AGE:

Years	Months	Days	If less than one day
77	3	11	...hrs. ...min.

9. Birthplace: London, Ontario, Canada
(Town, county, and state)

10. Usual occupation: Manager, grocery store

11. Industry or business: -

FATHER
12. Name: William Richards
13. Birthplace: England

MOTHER
14. Maiden name: Jane Cause
15. Birthplace: England

16. Informant: deceased
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 24, 1947 (month) (day) (year)

Cemetery or crematory:

Location: London, Ontario, Canada

18. Funeral director: The L. H. Hines Co.,

Address: 2901-14th St. N.W., Washington, DC

19. May 23, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1947 at 8 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/27 1938, to 5/23 1947

and that I last saw h.. alive on 5/23 1947

Immediate cause of death: pulmonary Tuberculosis — DURATION: 16 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: May 23, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04311

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
6519 - Annapolis Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6519 Annapolis Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Price Rose

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Elizabeth R Rose
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 22, 1897

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Cabinet Worker

11. Industry or business

FATHER
12. Name James Rose
13. Birthplace Virginia

MOTHER
14. Maiden name Mary Elizabeth Bledsoe
15. Birthplace Virginia

16. Informant Mrs Elizabeth R Rose
Address 6519 - Annapolis Rd

17. Burial (Burial, cremation, or removal: Which?) Date thereof May 6, 1947 (Month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Colmar Manor Md

18. Funeral director Francis Gray
Address Hyattsville Md.

19. 5/6 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Heart Failure	
Due to Hardening of arteries and chronic disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Respectfully Medical Examiner M. D. or other
Address Hyattsville Md Date signed 5-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

04302

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred:
4404 30th St., Mt. Rainier, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4404 30th St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3.(a) FULL NAME: BURTON EUGENE ROTHMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 27, 1927

8. AGE: Years	Months	Days	If less than one day
20			hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Printer
11. Industry or business

FATHER
12. Name: Richard E. Rothman
13. Birthplace: Montana

MOTHER
14. Maiden name: Lelia Cunningham
15. Birthplace: Virginia

16. Informant: Richard R. Rothman
Address: 4404 30th St., Mt. Rainier, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/47 (Month) (day) (year)
Cemetery or crematory: Arl. Nat. Cemetery
Location: Fort Myer Va.

18. Funeral director: Lee Edwards & Co.
Address: Riverdale, Md.

19. May 14, 1947 (Date rec'd by registrar) Mrs. Jas. Sewell Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1947, at 12:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Gun shot wound of head	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Homicide Date of injury 5-13-47
Where did injury occur? Mt. Rainier (City or town) Prince Geo. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Shot self in head Injury at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or Coroner
Address: Forestville, Md. Date signed 5-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 44 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

04303 231

Reg. Dist. No.

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5hrs.35min.
Hospital, institution, or street address where death occurred:
Prince George General
How long in hospital or institution? 5hrs.35min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr.Geo.
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 430 59th Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Schlatter,Mrs.Nannette

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17,1876

8. AGE: Years	Months	Days	If less than one day
71	2	9	hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation:
11. Industry or business

FATHER
12. Name: Sappington,William Geo.
13. Birthplace: England

MOTHER
14. Maiden name: Bronnock,Mary Cornelia
15. Birthplace: Md.

16. Informant: self
Address:

17. (Burial, cremation, or removal. Which?) Cremation Date thereof: May 28,1947 (month) (day) (year)
Cemetery or crematory: Ft.Lincoln
Location: Maryland.
18. Funeral director: W.H.Chambers
Address: 913-11th St. S.E.

19. 5/28 1947 (Date rec'd by registrar) Amanda Dooney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-26 19 47, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

DURATION

Immediate cause of death: mesentery Thrombosis
Due to: Cardiac arrest
renal disease
Due to:
Other conditions: Coronary sclerosis; Cardiac hypertrophy; Polycystic kidney.
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James J. Berry M. D. or other
Address: Westville, Md. Date signed: 5-27-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04304

CERTIFICATE OF DEATH

Reg. Dist. No. 245

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Mt. Rainier Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Hour
Hospital, Institution, or street address where death occurred:
4300 Raywood Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Mt Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4114- 29th St NE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SAMUEL SCHRIER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	married

6.(b) Name of ~~husband or~~ wife: Jetta
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years	Months	Days	If less than one day
51			....hrs. ....min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Grocer
11. Industry or business

FATHER
12. Name: Kalman Schrier
13. Birthplace: Russia

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant
Address

17. removal (Burial, cremation, or removal. Which?) Date thereof 5/21/1947 (month) (day) (year)
Cemetery or crematory: Wash. M. L.
Location

18. Funeral director: B. Danzansky & Son
Address 3501-14th St N.W.

19. 5/21/1947 (Date rec'd by registrar) Amanda Dooney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1947 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 27 1946 to May 21 1947 and that I last saw h.e.r. alive on May 21 1947

Immediate cause of death	DURATION
Ventricular Fibrillation	2 mins
Due to Myocardial Infarct	1 week
Due to Coronary Artery Disease	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

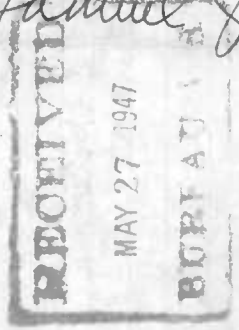
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Samuel J Kluger MD M. D. or other
Address Mt Rainier, Md. Date signed May 24 '47

Coroner James Boyd, M.D.
of Prince George's County, Md
was notified and ok'd release
of body.

Samuel J. Logan, M.D.



Evidence for the clarification of date of birth is shown on

G 11 MAY 23 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04305

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: Riverdale, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 minutes
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Greenbelt, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. 14 U Hillside Rd. (If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Mitchell Clayton Shade
3.(b) Social Security Number:

4. Sex: M.
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Edith Pearl Shade
7. Birth date of deceased (mo., day, yr.): June 29, 1881 (1881) June 29, 1881
6.(c) If alive, give age: 65 years
8. AGE: Years 65 Months 10 Days 28 If less than one day ... hrs. ... min.
9. Birthplace: Frederick County, Va. (Town, county, and state)
10. Usual occupation: Fireman (R.R.)
11. Industry or business:
FATHER 12. Name:
13. Birthplace: Va. unknown by son.
MOTHER 14. Maiden name: Unknown
15. Birthplace: Va.
16. Informant: Alaon L. Shade (son)
Address: Greenbelt, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-16-47 (month) (day) (year)
Cemetery or crematory: New Newbourne Cemetery
Location: Martinsburg, West Va.
18. Funeral director: W.W. Chambers Co.
Address: Riverdale, Md.
19. May 15 1947 James Sevey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/14, 1947, at 2:45 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/14 1947, to ... 19...
and that I last saw him alive on 5/14/47 19...
Immediate cause of death: Resp. failure due to Pulm. Edema — DURATION
Due to: Cardiac failure
Due to: arterio sclerotic Ht. disease
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: William L. Eisner M.D. or other
Address: Greenbelt, Md. Date signed: 5/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04306

93d

FILM No. G 110 MAY 22 1947

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Pr. George Hospital

How long in hospital or Institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Prince George

City or town: Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3718 - 35th St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lorenzo B. stephens.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Lena stephens

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): June 10 1866

8. AGE:

Years	Months	Days	If less than one day
81 80			...hrs. ...min.

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: Retired - Mechanic.

11. Industry or business

FATHER

12. Name: Geo. Stephens

13. Birthplace: Georgia

MOTHER

14. Maiden name: Mary Hall

15. Birthplace: Georgia

16. Informant: Lena L. Stephens

Address: same address 81

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1947. (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Washington D.C.

18. Funeral director: F Gudgie sons

Address: Hyattsville Md

19. 5/19/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-16 1947 at 1:25 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-8 1947, to 5-16 1947 and that I last saw h...alive on 5-15 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	8 days
Due to: Hypertension cardiac.	
Vascular Disease	10 years
Due to:	
Other conditions: Cerebral arteriosclerosis	2 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: C. B. Smoyer M.D. M. D. or other

Address: Mt. Rainier Md Date signed 5-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04367

136

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 19 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Gospel Mission, Washington, D. C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILBUR WORTH STEVENSON

3.(b) Social Security Number: 412-10-8026

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Eva Brown Halloway
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): April 16, 1913

8. AGE: Years	Months	Days	If less than one day
34 34	-	15	hrs. min.

9. Birthplace: Roanoke, Alabama (Town, county, and state)
10. Usual occupation: Printer
11. Industry or business: - - -

FATHER
12. Name: Leon M. Stevenson
13. Birthplace: - - - - -

MOTHER
14. Maiden name: Alma Oliver
15. Birthplace: Alabama

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/47 (month) (day) (year)
Cemetery or crematory: Washington National
Location: Suitland Md.
18. Funeral director: W. H. Chambers Co.
Address: 3072 M St. N.W. Wash. D.C

19. May 1, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1st 1947, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 11th 1947 to May 1st 1947 and that I last saw h[illegible] alive on May 1st 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: May 1, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 a

04308

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:

County Pr. Geo.

City or town 6230 Walkersmills Rd S-E

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Pr. Geo.

City or town Walkersmill Rd. S.E.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6230

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ANNIE C. TAYLOR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

B.(b) Name of husband or wife Phillip Taylor.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 28 - 1875

8. AGE: Years	Months	Days	If less than one day
72.			..... hrs. ..... min.

9. Birthplace Lynnwoodlan - Prince Geo County (Town, county, and state)

10. Usual occupation Domestic.

11. Industry or business

FATHER 12. Name William Muse.

13. Birthplace Md.

MOTHER 14. Maiden name Mary Henson.

15. Birthplace Md.

16. Informant Harmony Century

Address Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 28. 1947 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Ruff Barbour

Address 48 - K St N.E.

19. May 23 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 11.55 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 28 1947, to May 22 1947

and that I last saw h alive on May 22 1947

Immediate cause of death	DURATION
Acute Cardiac Failure	4 hrs
due to Sclerosis	
Due to Cardio - Vascular Renal Disease	
Due to	
Other conditions Chronic Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Luther J. Scott M.D. M. D. or other

Address 2504 Nichols Ave Date signed 5-23-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a 04309

CERTIFICATE OF DEATH

Reg. Diat. No. 230

1. PLACE OF DEATH:
County: Prince George's
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: Montgomery Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Montgomery Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOSEPH FORD TAYLOR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emily C. Taylor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 2, 1888

8. AGE: Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Real Estate Dealer

FATHER
12. Name: William Henry Taylor
13. Birthplace: Penn.

MOTHER
14. Maiden name: Elizabeth Blackston Riley
15. Birthplace: Washington, D.C.

16. Informant: Chalrs George Taylor
Address: Berwyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/2/47 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D.C.

18. Funeral director: W.W. Chamberlin & Co.
Address: Riverdale Md

19. May 31 19 47 (Date rec'd by registrar) Ma. Jno. Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 19 47, at 5:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Asphyxia	
Due to: Hanging	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 5/30/47
Where did injury occur? Berwyn (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Barn on farm
Means of injury: Hanged self with rope Injured at work?

Deputy Medical Examiner
23. SIGNATURE: James D. Boyd M. D. or Coroner
Address: Forestville, Md. Date signed 5/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04310

Reg. Dist. No. 265

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Prince George's

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Used to summer

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4004 Gallatin Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: HARRY PAUL THOMPSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nora A. Thompson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1893

8. AGE:	Years	Months	Days	If less than one day
	53			..... hrs. ..... min.

9. Birthplace: New York State (Town, county, and state)

10. Usual occupation: Retired Painter

11. Industry or business:

FATHER — 12. Name: Thompson

13. Birthplace: New York, City

MOTHER — 14. Maiden name: Mary Slovoki

15. Birthplace: Italy

16. Informant: Nora A. Thompson (wife)

Address: 4004 Gallatin St. Hyattsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: Washington, D.C.

18. Funeral director: W.W. Chambers Co. RMB

Address: 5801 Cleveland Ave. Riverdale, Md.

19. May 21 1947 James Sevens

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 1947, at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Deputy medical Examiner

23. SIGNATURE: James J. Ford M. D. or Other

Address: Hyattsville Md. Date signed: 5-21-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b

Reg. Dist. No. 04211 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 days

Hospital, Institution, or street address where death occurred:
Eugene Gleed Memorial Hospital

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County: —

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 822-6th St. N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Van Sant Mrs. Mary Alice

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	Widowed

6.(b) Name of husband or wife: Thomas James Van Sant deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 29 1867

8. AGE: Years: 80 Months: — Days: — If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Retired Price Marker

11. Industry or business:

FATHER
12. Name: George Wooldridge
13. Birthplace: New York

MOTHER
14. Maiden name: Julia Anna Harbaugh
15. Birthplace: Washington D.C.

16. Informant: Hospital Records

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 19 1947 (month) (day) (year)

Cemetery or crematory:

Location: 300-44 St N or Wash DC

18. Funeral director: J. Wm Lee Sons

Address: 7300 4th St NE

19. May 19 47 (Date rec'd by registrar) James Seary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/19/47 19..... at 1 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1947 to May 19, 1947 and that I last saw h.e alive on May 19, 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: General Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L W Malin MD M. D. or other

Address: 4404 Queensbury Rd. Riverdale Md Date signed: 5/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04312

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hours.

Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 10 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4605 Lackawanna.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Michael Wagner.

3.(b) Social Security Number:

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Deborah Wagner.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Mar 1, 1872

8. AGE: Years: 75 Months: 1 Days: 21 If less than one day: ..... hrs. ..... min.

9. Birthplace: Dist. of Col. (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Steam.

FATHER

12. Name: Charles Wagner

13. Birthplace: .....

MOTHER

14. Maiden name: Margaret Beck.

15. Birthplace: Luxenburg

16. Informant: Catherine Bosse.

Address: 4605 Lackawanna St. Berwyn, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 24 1947 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Wash. D. C.

18. Funeral director: William J. Malloy.

Address: 3200 - R. I. Ave, Mt. Rainier, Md.

19. May 23 1947 (Date rec'd by registrar) James Sevis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1947, at 1 28 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 22 1947

and that I last saw h.. alive on May 22 1947

	DURATION
Immediate cause of death: Coronary Thrombosis.	1 Day
Due to: arterio sclerotic Heart Dis.	10 yrs
Due to: General arterio sclerosis.	12 yrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L W Maleu M D M. D. or other

Address: Riverdale, Md Date signed: 5-22-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04313

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1461 Girard St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ALICE WALDON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Kenneth Waldon

6.(c) If alive, give age: — — years

7. Birth date of deceased (mo., day, yr.): January 2, 1916

8. AGE: Years	Months	Days	If less than one day
31	4	6	hrs. min.

9. Birthplace: Little Creek, Pennsylvania
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: — — — —

FATHER
12. Name: John Hagwood
13. Birthplace: — — — —

MOTHER
14. Maiden name: Harriet Burrell
15. Birthplace: Culpeper, Virginia

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 9 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C

18. Funeral director: Robert F. McGuire

Address: 1820 - 9th St. N.W. Wash. D.C

19. May 8, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1947, at 5:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 24, 1947, to May 8, 1947 and that I last saw her alive on May 7, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 Mo.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glen Dale, Md. Date signed: May 8, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

04314

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fairmont Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

1002 - 59th Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Fairmont Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1002 - 59th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Victor De Writers Waugh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 29, 1947

8. AGE: Years | Months /X | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D.C.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Daniel Gibson

13. Birthplace South Carolina

MOTHER 14. Maiden name Bettie Jane Waugh

15. Birthplace Washington D.C.

16. Informant Bettie Jane Waugh

Address 1002 - 59th Ave, Fairmont Hts

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 20 47 (month) (day) (year)

Cemetery or crematory

Location Washington D.C.

18. Funeral director Henry L. Washington & Sons

Address 467 N St. N.W. Wash. D.C.

19. May 20 19 47 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 47, at 5-02 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Asphyxia	
Due to: Something in bed clothing	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-20-47

Where did injury occur? Fairmont Hts. (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Smothered in bed Injured by

Deputy medical examiner

23. SIGNATURE ..... M. D. or other

Address Westville Md. Date signed 5-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04315

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6207 Lee Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Baby Wilkinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 4, 1947

8. AGE: Years | Months | Days | If less than one day: ..... hrs. 3 min.

9. Birthplace: Cedar Heights, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Curtis Wilkinson
13. Birthplace: Cedar Heights

MOTHER
14. Maiden name: Nellie Black
15. Birthplace: Chester, South Carolina

16. Informant: Curtis Wilkinson
Address: Cedar Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4, 1947 (month) (day) (year)
Cemetery or crematory: Own Home
Location: Cedar Heights, Md.

18. Funeral director: Curtis Wilkinson
Address: 6207 Lee pl. N.E.

19. 5/6 (Date rec'd by registrar) 1947 Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 19 47 at 11:33 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
Due to premature	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Mrs. Hattie H. Sutton, M. D. or other
Address: 6311 L St. Cedar Hgts. Md. Date signed 5/5/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13a 04316 231

Reg. Dist. No. .....

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County Prince George

City or town Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Hillcrest Manor Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 4103 53rd Ave (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Louis J. Woytych

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Elizabeth (Brady) 6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 29 1888

8. AGE: Years	Months	Days	If less than one day
59			....hrs. ....min.

9. Birthplace Baltimore (Town, county, and state) Maryland

10. Usual occupation Deputy Clerk of Customs

11. Industry or business .....

FATHER 12. Name John B. Woytych

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Catherine Wilting

MOTHER 15. Birthplace Germany

16. Informant Louis B. Woytych

Address 12 Revell St. Arnold Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1947 (month) (day) (year)

Cemetery or crematory St Mary's

Location Annapolis Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. May 19 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/17 1947 at 8 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/29 1947 to 5/17 1947

and that I last saw him alive on 5/17 1947

Immediate cause of death	DURATION
Uremia	5/16/47
Hemiplegia left side	
Due to Chronic glomerulo nephritis	
Due to Hypertensive heart & renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE George J. Hageage M. D. or other

Address 3717 - 38th Ave Date signed 5/17/47